Kansas Medical Assistance Programs

HEALTHCONNECT Kansas
From the office of the Fiscal Agent

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Regranex Renewal Request Form

Consumer Name: _____
Consumer Medicaid ID #: _____ **Date Of Birth:** ____/____/_____
Pharmacy Name: _____ **Provider Medicaid ID#:** _____
Phone Number: (_____)_____ **Fax Number: (_____)_____**

Ordering Physician Name (*please print*):_____
Ordering Physician Medicaid Provider ID#: _____
Phone Number: (_____)_____ Fax Number: (_____)_____

Does the consumer have any new wounds for which Regranex is being prescribed? _____
(Does not include initial wound(s) for which medication was ordered.) If so, please complete the ***Regranex Initial Request Form.*** Call 1-800-285-4978 and select option 4 to obtain a copy.

If this request is for renewal for the same wound(s) as previously ordered, please complete the following:
Wound Information: (*Please check appropriate type)*
___Arterial ___Venous ___Pressure ___Diabetic ___Surgical ___Burn ___Other:_____

Wound location when Regranex started: _____

Wound size when Regranex started: _____ Date: ____/____/_____

Current wound size: _____ Date of measurement: ____/____/_____

How long has the wound been treated with Regranex? _____

If Regranex has been used longer than 10 weeks, has the wound decreased in size by at least 30%?

_____

In your opinion, is the consumer/caregiver compliant with proper use and storage of this medication?

_____

Provider Signature: _____ Date: ____/____/_____

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.

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